C157 & UNC2 REVIEW SESSION

Application of Course Content
COMPETENCIES

• Competency 7004.1.1: Nursing and Inter-professional Standards
• Competency 7004.1.2: Evaluating and Documenting Innovations

APPLICATION!!
PDSA

Process improvement should be completed in a systematic, organized manner (PDSA).
• The first step in a QI project is to determine needs (so we can develop the Aim).
• QI is always, always, always based on Needs!
MEASUREMENT

• Measures are established so that we can determine the success or failure of the change implemented in a QI project.
• Baseline Measurement: Says ‘yep, that’s a real problem’
• Re-measurements: Tell us what happened after the change
• The best measurement tells us precisely about the process and population in question.
  • Apples to Apples
BASELINE MEASUREMENT

Data used to:
• Substantiate the importance for change.
• Support the need to spend resources.
• Provide a baseline for comparison after a change takes place.

Always consider the target population and the target process.
Clinical leadership in a large healthcare system is committed to assisting patients to engage in healthy lifestyle behaviors. The team is determining the need for a weight-loss support program at one of its clinics.

What information is required in order to determine the need for such a program?

• Percentage of pts who are overweight & have expressed interest in losing weight
• Percentage of pts who are overweight & have recently attempted to change their diets
• Percentage of pts who have successfully lost weight & are now struggling to maintain their weight
• Percentage of pts who are overweight who have requested information on bariatric
An acute care hospital wants to change their information sharing policy. They currently share the following information with pts only: diagnoses, care planning, medications, activity, & discharge information.

They want to change the HIPAA privacy policy to enable personal health information to be shared with any person a patient gives permission to have access. Clinical staff are concerned because expanding access to patient information will cause them additional cross-checking work prior to being able to direct visitors to answer questions about a patient's care. Hospital administration is considering this change as a way to enhance patient-centered care.

How should this change be evaluated to determine if it is successful?

• Compare quality care metrics of medication reconciliation pre-policy and post-policy change
• Compare quality care metrics between the acute hospital and the skilled nurse facility
• Compare patient satisfaction metrics between pre-policy and post-policy change
• Compare clinical staff satisfaction metrics between pre-policy and post-policy change
Scenario: A healthcare organization is collecting data about the quality of the nursing care in regards to effective coordination of care.

What data/measurement will tell us precisely what is going on with this process?

- Root cause analysis of a patient fall that occurred during transfer from one nursing unit to another.
- Readmission rate increase of 2% to 3% for patients transitioning to long term care.
- Nursing staff survey: 75% believe coordination of care is effective.
- Patient satisfaction survey: 60% were satisfied with discharge education.
To incorporate national standards and best practices into QI, we would consult authorities in the field (examples: CDC, AHRQ, Joint Commission, etc.).

Three benchmark domains must be considered when evaluating evidence: quality, quantity, and consistency.

Benchmarks are used to establish patient outcome goals.

Benchmarks are often closely associated with standards.

Organizational Goals vs. Benchmarks

- Goals – Internal to the Organization
- Benchmarks – External to the Organization
  - Competitor Performance
  - Industry Standard
NATIONAL PATIENT SAFETY GOALS

• Key Standard
• Integral part of an organization’s patient safety program
• Developed from Sentinel Event reports received by the Joint Commission
  • Sentinel Event = adverse event resulting in death or permanent harm; root cause analysis is performed
  • Common root causes of Sentinel Events:
    • Ineffective Communication
    • Leadership Issues
    • Human Factors (aka Human Error)
• Never Events – “Preventable”
  • Benchmark/Goal is Zero!
  • Examples: Healthcare Acquired Infections, Falls, etc.
CMS NO PAY EVENTS

Category 1 – Health Care-Acquired Conditions (For Any Inpatient Hospitals Settings in Medicaid)
• Foreign Object Retained After Surgery
• Air Embolism
• Blood Incompatibility
• Stage III and IV Pressure Ulcers
• Falls and Trauma (Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burns, Electric Shock)
• Catheter-Associated Urinary Tract Infection (CAUTI)
• Vascular Catheter-Associated Infection (CLABS)
• Manifestations of Poor Glycemic Control (Diabetic Ketoacidosis, Hypoglycemic Coma, etc.)
• Surgical Site Infection Following:
  • Coronary Artery Bypass Graft (Mediastinitis); Bariatric Surgery, and certain Orthopedic Procedures
  • DVT or PE following Total Knee or Hip Replacement

Category 2 – Other Provider Preventable Conditions (For Any Health Care Setting)
• Wrong site, wrong procedure, and wrong patient surgery
AIM, MEASUREMENT, CHANGE

• After a year of working on a project to prevent falls, we have a decrease in the fall rate of 60%. What is the next step in the QI process?

• Identify new process improvement goals and activities for the unit
• Establish a goal to reduce patient falls by an additional 20% next year.
• Continue process improvement activities and monitoring of patient falls
• Examine the data to see which units and what patients were most affected
• We’ve been informed that there was an increase in CAUTI infection rate from 3% to 5% over a one month period. What should we do next?

• Identify new process improvement goals and activities for the unit
• Continue process improvement activities and monitoring of CAUTI
• Establish a goal to reduce CAUTI to <3%.
• Examine the data to determine the trend of CAUTI
FREQUENCIES

• A number of events per a particular volume
  • Fall rate – a frequency of falls per occupied bed days
  • Infection rates – a frequency of infections per catheter days or line insertions
    • CLABSIs
    • CAUTIs

NOT a straight number of events!
• Evidence! CPGs! Pilot studies!
  • Answering “does it work?”
  • Our basic goal is to reduce risk to patients (and to our staff & organization).
  • Remember: We don’t have a lot of resources to waste on things that don’t work!

• A nurse’s commitment to patient centered care is demonstrated by developing plans based on the best evidence.

• MSNs must review the literature to determine the best evidence for change.

• Reading about similar QI projects in journals is a strategy that can be used to design successful QI plans (Plan in PDSA).

• If no existing evidence: Pilot Test!
  • Try out the change on a small scale before rolling it out organization-wide.

HOW TO SELECT & PLAN THE CHANGE?
We review the evidence after problem identification (assessment of needs) has occurred.

- Again, we’re striving for good alignment between the need and the change.

- Evidence-based practice and quality management are both practice-driven processes, informed by experience and outcomes that can be directly seen and measured (objective information).
Based on patient survey data that indicate patients were dissatisfied with the level of noise on the patient care unit, the QI team has recommended the use of a sound machine in each patient room to muffle the ambient noise on the unit.

How should the MSN respond to this recommendation?

• The MSN should serve as a champion & role model during the implementation of the recommendation.
• The MSN should search the literature to confirm that the recommendation is evidence-based.
• The MSN should support the recommendation, as it is an effort that will improve patient care.
• The MSN should clarify how the data were collected and how the team developed its recommendation.
PLANNING THE CHANGE

• Make the distinction between the
  • Process being improved or changed
  • Interventions being deployed to make the change happen

• A good plan for a process change includes:
  • Interventions
  • Assignments
  • Deadlines
  • A plan for data collection and analysis
    • These often involve different cycles, different procedures, different people
To obtain quantitative data or objective evidence about a problem, we need to test, measure, or observe directly.

Surveys, focus groups, and interviews of staff or patients yield qualitative or subjective information. (Asking patients, checking with staff, a person’s belief, someone said, etc. = subjective information.) This information provides context or people’s experiences of problems.
Based on observation, an NP believes that the rates of smoking and obesity are increasing in their patient population and wants to implement a program to address this issue in the ambulatory clinic.

What is the 1st step the NP should take to determine if this belief is, in fact, a trend?

- Work with the practice manager to determine rates of smoking and obesity in the practice
- Ask the other staff if they are seeing increasing numbers of patients who are smoking and/or obese
- Ask patients if they feel that either smoking or obesity is affecting their lifestyle
- Work with the staff to counsel each patient on the dangers of smoking and the risk factors of obesity
• Sampling can help us obtain data cheaply and quickly for rapid cycle quality improvement (PDSA).

• Example: Hand hygiene observations: Measuring EVERY opportunity to perform hand hygiene would be expensive and time-consuming.

• For QI projects that intend to reduce healthcare acquired infections, we need to understand both monitoring and prevention.
The IHI Triple Aim

Population Health

Experience of Care  Per Capita Cost
To evaluate or Study (PDSA) a QI project, we need to compare the re-measurements taken post change with the baseline measurement taken before the change. This will allow us to decide if any improvement occurred.

We also need to compare the re-measurements with the goals set at the beginning of the project to see if we met/did not meet these.

Did we meet our deadlines?

After we STUDY, we ACT!

- Sometimes this means we need to assess Needs again to develop new AIMS and start a new cycle of PDSA.
• Objective vs. Subjective information
  • Objective evidence: test it, measure it, or observe it directly
  • Subjective: touchy-feely reasons and recollections (why and how)

• Single vs. Multiple data points
  • Need to be able to determine trends and make comparisons with baseline measurements, benchmarks, and goals
How would you know that a patient with diabetes has good blood glucose control?

• Patient had a blood glucose within normal range during the last visit
• Patient who is compliant with meds had a normal blood glucose during last appointment
• Patient had blood glucose within normal range as stated by the staff in the clinic
• Patient has had blood glucose measurements within normal range over 6 months
ACT: COMMUNICATING RESULTS

- QI tools:
  - Run charts, Control charts—variations over time
  - Bar graphs and pie charts—categories, volume, capacity, etc. (examples of bar graphs: Pareto, Histogram)
  - Standard deviation—process dispersion, how narrow or wide apart are the data?
  - Mean (Average)—preferred measure of central tendency

What does the data tells us? Trends? Improvement? Goals? Deadlines?
Where to from here? Additional Interventions? Sustainment? New PDSA cycle?
ROOT CAUSE ANALYSIS

• We’re examining and learning from a single (often catastrophic) event. Investigated by using
  • Flowcharts
  • Fishbone diagrams
    Note: flowcharts can also help us design new processes (i.e. algorithm)
ADVANCED PRACTICE ROLE

• Key ideas:
  • Support engagement of team members
    • Participate, Facilitate, Collaborate, Negotiate
  • Effective communication
  • Effective leadership
  • Conflict resolution
  • Shared decision making (patients)
  • Shared governance (nurses and other staff)
  • Patient centered care
  • Culture of safety—learn about human error and create better systems!
  • Think BIG—Big urban hospitals, process from start to finish (not just your part)
    • Example—the pain pump!
ESSENTIALS OF MASTERS ED IN NURSING

• Key Standard
• Used to design MSN curriculum
• Used by university surveyors to determine whether accreditation standards have been met
• By earning an MSN at WGU, you are meeting these standards!

• MSNs (more so than BSNs or associate prepared nurses) should have a deeper understanding of nursing or an expanded range of nursing knowledge.
IOM (2001) Six Aims for Improvement

**Patient-centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

**Effective**: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.

**Safe**: avoiding injuries to patients from the care that is intended to help them.

**Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care.

**Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy.

**Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
Objective: Move away from blaming individuals for adverse events and work to correct our systems and processes.

Good people are working in Bad Systems!
QSEN indicates that MSNs should promote systems that reduce reliance on memory to make care safer.

Examples of system-related interventions that reduce staff reliance on memory:

- Checklists
- Worksheets
- Standard order sets
- Standardized timelines
- Adding fields for documentation in records.

All of these serve as ‘reminders’ or ‘prompts’.
INTER-PROFESSIONAL COLLABORATION

• Health professionals work together in small groups providing care, be it oncology, the operating room, end of life, or primary care.
  • Although most patient care is being done by teams of people, training is often focused on individual responsibilities and does not prepare them for complex settings.
  • Team members are educated in their health profession silo and likely have little knowledge of their team members’ skill sets.

• The 2000 IOM report, To Err is Human:
  • Suggested that health professionals should be educated in teams using evidenced-based methods such as simulation and checklists.
    • People make fewer errors when they work in effective teams!
    • Processes must be planned and standardized.
    • Team members know their role and that of other team members.
    • Team members can look out for one another, noticing errors before they become an accident.
  • In an effective inter-professional team, members come to trust each other’s judgments and attend to one another’s safety concerns.
ADVANCED NURSING PRACTICE

• “Interprofessional” Collaboration
  • Nurses, physicians, ancillary staff, patients, and other stakeholders working together to solve problems.
  • Team building-
    • Phases: Form, Storm, Norm, Perform
    • Dependent upon: Conflict Resolution & Negotiation Skills, Collaboration, and the correct application of Power
    • Benefits: Agreement on Decisions, Empowerment, Effective Communication, and Trust!
Emotional intelligence is the awareness of the role emotion plays in personal relationships and the purposeful use of emotion to communicate, build rapport, and motivate self and others.

People with high emotional intelligence are more effective on teams and can help make change transitions easier. These are our Change Agents!
A nurse serving as a member of an evidence-based practice (EBP) team has noticed that another EBP team member rarely speaks during the team's meetings. What is the responsibility of the nurse to this EBP team member?

- Encourage the team member's participation in meetings
- Report identified concerns to the team leader
- Develop a proposal for team member expectations
- Suggest that the team member be reassigned
INTER-PROFESSIONAL TEAMS

• The act of collaboration in an inter-professional team might be best exemplified by defining patient goals individually and then coming together as a team to select the most important ones. Care is too complex today for a single discipline to direct all other caregivers and disciplines represented on an inter-professional team. Each team member must become as proficient in communication skills as they are in clinical skills.

• The advanced nursing role centers on acting with a high level of integrity by
  • Giving power and respect to each team member’s voice
  • Integrating individual differences
  • Resolving competing interests in order to safeguard each person’s contribution
Population-based Interventions:

- Focus on entire populations possessing similar health concerns or characteristics.
- Are guided by an assessment of population health status.
- Consider broad determinants of health (socioeconomic status, education, environment, support systems, etc.).
- Consider all levels of prevention, with a preference for primary prevention.
  - Primary prevention: Keeps problems from happening in the first place.
  - Secondary prevention: Detects problems in early stages usually before signs/symptoms appear and before it affects others.
  - Tertiary prevention: Keeps existing problems from becoming worse with a goal of restoring optimal quality of life.
Begins by identifying the Target of an intervention:

- **Population of interest**
  - Essentially healthy, but who could benefit from health promotion activities
- **Population at risk**
  - Common identified risk factor or risk-exposure that poses a threat to health

And then the **Level of Practice**:

- **Community** –
  - Changes community norms, community awareness, community attitudes, practices, & behaviors.
  - Measurement: What proportion of the population actually changed?
- **System** -
  - Changes organizations, policies, laws, and power structures. The focus is not directly on individuals and communities but on the systems that impact them.
  - **Changing systems** is often the most effective and long-lasting way to impact population health rather than requiring change from every single individual.
- **Individual/family** -
  - Changes knowledge, attitudes, beliefs, practices, and behaviors of individuals.
  - Practice level is directed at individuals, alone or as part of a family, class, or group.
  - Example of a class or group: OB patients

**PATIENT CENTERED CARE**
Population of Interest: All children with special needs & their families

Problem: Fragmented service delivery system

Community Intervention:
• An MSN working with a local advocacy organization presents programs about the rights of children under the ADA to various parent groups in the community. The programs emphasize how parents can advocate for their children.

System Intervention:
• An MSN works with an inter-professional team who provide services to children with special needs to cooperatively design a centralized intake process to simplify access to these services.

Individual/Family Intervention:
• An MSN is working with the family of a school-aged boy who uses a wheelchair due to cerebral palsy. The MSN helps the family and their primary care provider in negotiating a plan with the school district to meet the child’s educational and physical needs during the school day.
PATIENT CENTERED CARE

Quote from text: “A distinguishing feature of evidence-based nursing is that nurses treat and work with patients rather than work on them.”

• Think about the Patient Experience:
  • Patients should be encouraged to be full participants in their care.
  • Patients need support especially during care transitions.

• Think about Ethical Communications:
  • Autonomy, Beneficence, Veracity, Justice

• Think about Patient Education:
  • Communication in plain language (avoid medical terminology or jargon)
  • Written education to take home
  • Consider: Literacy or other barriers to learning
A pediatrics office is offering a baseline pre-concussion mental exam for their adolescent athletes. Studies have shown that the exam is beneficial in the event of a concussion, as it will show the deviation from baseline when the exam is performed post-concussion. Few patients have heard of this cutting edge exam, and the office is trying to determine the best way to make parents aware of the additional screening. What is the most effective way to help acquaint them with the offering?

- Display a poster in the waiting room that discusses concussion risks & prevention techniques.
- Provide written education, in plain language, at all well-child checks for ages 12 and up.
- Have parents complete a form about their child, and offer education to those who have a child in a contact sport.
- Have the providers discuss the exam at well-child visits, and let the parents take home a sample.
• Best Practices
  • Foster development of the client’s capacity to advocate on their own behalf!
  • Use mass media in conjunction with advocacy.
  • Assume an assertive or protective stance if/when appropriate.
  • Exhibit self-confidence, strength of conviction, and a commitment to social justice.
    • Justice = Equity (i.e. equal access)

Advocacy is often viewed as a precursor to policy development!
• **Advanced role of nurse advocate:** MSN is positioned to advocate for those who are unable to have a voice in the decision-making process.

• **Vulnerable patient populations** (elderly, infants, persons with reduced capacity for informed decision making) continue to need ongoing nursing care.

• MSN has the skills to participate in policy formation to ensure that these patient populations have their needs addressed.
Nursing informatics has grown past the point where nurses simply help IT to design electronic medical record (EMR) screens and choose equipment. Now this role is an integral part of healthcare delivery and a differentiating factor in the selection, implementation, and evaluation of health IT that supports safe, high quality, patient-centric care.

The MSN in the advanced role would advocate for implementation of decision support systems.
Cultural competence is a compilation of the clinical skills and professional behaviors of a healthcare provider focused on the cultural values, beliefs, and perceptions of the consumer while both are engaged in the therapeutic relationship.
PSYCHOLOGICAL SAFETY

• Culture of Safety?
  • By reducing the emphasis on blame & shame, staff feel safe to report errors.
  • Increased incident reports should result in more opportunities for organizational learning.
    • Remember: Increased numbers of incident reports do not mean increased numbers of incidences! May be an indicator of psychological safety.
Coercive power—often related to negative attributes
  - Using one’s authority in a negative way—especially to shut down communication! “Do it because I said to.”

Reward power—often related to money/materialism
  - Satisfaction lasts about as long as the money does!
  - Need to strive for intrinsic motivation—finding out what matters to people!

Positional power—related to the job description
  - Managing people, resources, committees, programs, or service lines

Referent power—related to one’s personality, reputation, or actions

Expert power—power related to one’s knowledge & expertise
INFLUENCE VS. AUTHORITY

• Advanced Roles with large domains of **Influence**:
  • QI Manager, Infection Control Practitioner
  • Lead & manage programs and committees that cross service lines & involve multiple professions
  • Use evidence to “make a compelling case” that will convince people to do the right thing
  • Perform organizational risk assessment that helps steer the organization in a particular direction
  • Often little to no budget or staff
  • Usually not very close to the front line

• Advanced Roles with large domains of **Authority**:
  • Nurse Manager, Nurse Administrator, CNO
  • Lead & manage resources (money, personnel, etc.)
  • Hire & fire, manage a budget, responsible for the activities of multiple personnel
  • Day-to-day monitoring and on-the-spot correction
  • Manages service lines, units, wards
  • Often close to the front line

All advanced nursing roles have varying degrees of authority & influence!
Which role should an infection control nurse have in a QI program of decreasing CLABSI rates?

- Spot check ongoing workflow & determine appropriate places in the clinical workflow to improve the process or provide re-training
- Determine if this is a worthy QI program for the patient population along with the QI personnel
- Institute re-training each time there are day-to-day fluctuations in rates reported in infection control reports monitoring ongoing process
- Monitor day-to-day progress during the QI program to determine improvements that can be made to the process
• What tools and information can we use to influence/persuade/convince (our expert power)?
  • Data collection and analysis
  • Standards
  • EBP/Clinical Practice Guidelines
  • QI Tools - flowcharts, run charts, root cause analysis, PDSA, etc.

• Have to make a compelling case for change!
• Reduce risk to patients (and staff/organization).
• Need to avoid spending resources on “improvements” that do not work!
How do we need to act (our referent power)?

- Facilitate communication (Are we trying to elicit feedback or shut people down?)
- Foster relationships.
- Break down silos of information.
- Lead and manage change.
- Focus on faults in systems not faults in individuals (avoid blaming & shaming).

“Tart words make no friends; a spoonful of honey will catch more flies than a gallon of vinegar.”

— Benjamin Franklin
Nursing leadership in a 750-bed tertiary care facility has been advised that quality measures affecting reimbursement are going to be captured to assess progress toward the following goals:

• Improve the quality of care transitions and communications across care settings.
• Improve the quality of life for patients with chronic illness and disability.
• Establish shared accountability and integration of communities and health care systems.

A program is needed to improve the coordination of care as patients transition to other care settings.

What role should the QI team have in program to improve communication and care transitions?

• Check with patient families of discharged patients to ensure home care contacted them in a timely fashion and had the necessary info to provide high quality care.
• Check each patient discharged for a 2-week period to a skilled nursing facility or an assisted-living facility to be sure the correct paperwork was sent or transmitted to the facility.
• Determine if current practice meets the metrics established for the measure or if this is a QI program needed to improve the quality of care delivered.
• Determine whether receiving facilities are interested in a QI program initiated by the sending facility.
Our objective is to stop being the ‘doer’.

We’re looking to delegate responsibility to a subordinate who is the complete package in terms of time, competency, and interpersonal skills.
  • Competency = application/demonstration of knowledge

Want to avoid delegation to person who will need micromanagement!

It’s a great time to begin mentoring a colleague into advanced practice!
MENTORING VS. PRECEPTING

• Mentor
  • Selected by nurse
  • Trusted Advisor
  • Helps usher a colleague into advanced practice
  • Could be a long term relationship!

• Preceptor
  • Assigned by supervisor
  • Tasks to complete and Deadlines to meet
  • Typically a short term relationship (length of assignment)
QUESTIONS?